methacin should be used in addition to pancreatic stents in high-risk patients. However, post hoc analysis of our trial suggests that indomethacin may obviate the need for prophylactic pancreatic stent placement (unpublished data), and we therefore agree with Baron et al. that comparative effectiveness studies of indomethacin and pancreatic stenting are necessary.

In response to Crippa et al.: we enrolled patients at high risk for post-ERCP pancreatitis (with clinical suspicion of sphincter of Oddi dysfunction in >80% and pancreatography performed in >85%), whereas Sotoudehmanesh et al. enrolled mostly low-risk patients (with clinical suspicion of sphincter of Oddi dysfunction in 8% and pancreatography performed in 18%).[1] This difference in study samples almost certainly accounts for the difference in post-ERCP pancreatitis rates between the two trials in both the indomethacin group and the placebo group. Nevertheless, we agree that it remains unclear whether administration of rectal indomethacin before or after ERCP is most effective; current guidelines support the use of either approach.[2] Studies addressing the clinical pharmacology of prophylactic indomethacin, including timing and dosage, are needed.

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Since publication of his article, the author reports no further potential conflict of interest.

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More on Treatment for Acute Anterior Cruciate Ligament Tears

TO THE EDITOR: We previously published results of our randomized trial of treatment for anterior cruciate ligament tears (July 22, 2010, issue).[1] In Table 3 of that article, which shows primary, secondary, and exploratory outcomes at 2 years, the P values and confidence intervals were calculated in compliance with the "Points to Consider on Adjustment for Baseline Covariates," in the European Medicines Agency guidelines a distinction that was not stated in the article. Accordingly, the P values were adjusted for baseline value, whereas the unadjusted confidence intervals were calculated by maximum-likelihood estimation. There were no significant between-group differences in either the adjusted analysis or the unadjusted analysis, and thus the difference between the two results does not affect our conclusions. In order to clarify our results, we have provided a table that includes the unadjusted P values and the adjusted 95% confidence intervals in the Supplementary Appendix, available with the full text of this letter at NEJM.org.

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1. Frobell RB, Roos EM, Roos HP, Ranstam J, Lohmander LS. A randomized trial of treatment for acute anterior cruciate ligament tears. N Engl J Med 2010;363:331-42. [Erratum, N Engl J Med 2010;363:893.]

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Alopecia Areata

TO THE EDITOR: In their review article on alopecia areata, Gilhar et al. (April 19 issue)[1] do not mention psoralen–ultraviolet A (PUVA) photochemotherapy. This was probably because there have been no published controlled studies of this local immunosuppressive treatment for extensive alopecia areata.[2] However, reported response rates are typically as good as those for contact immunotherapy, which is supported by only slightly better evidence, with half-scalp comparative studies confirming an effect.[3] Contact immunotherapy involves the discomfort of a medically induced dermatitis every week; PUVA only rarely causes localized phototoxic responses. In